T. R. No. 16

Technical Report

HEALTH CARE FOR THE PEOPLE : THE EMPIRICS OF THE NEW RURAL HEALTH SCHEME

RADHIKA RAMASUBBAN

THE GIRI INSTITUTE OF DEVELOPMENT STUDIES
LUCKNOW

T.R. No.16

HEALTH CARE FOR THE PEOPLE : THE EMPIRICS OF THE NEW RURAL HEALTH SCHEME

RADHIKA RAMASUBBAN

July, 1978

HEALTH CARE FOR THE PEOPLE :

THE EMPIRICS OF THE NEW RURAL HEALTH SCHEME

Radhika Ramasubban

The new rural health scheme of providing every village in the country with a health worker chosen from among the villagers themselves and trained and financially-supported by the government, was launched with much fanfare on 2nd October, 1977. The auspicious date is probably supposed to signify the Janata Government's vindication of its Gandhian image : a 'rural' and 'mass' bias, and a 'creative integration' of the allopathic and traditional Indian systems of medicine with a view to evolving a new national pattern suited to the Indian genius and conditions. But we must confess to a suspicion of Himalayan proportions that the Gandhian gloss notwithstanding, the usual Indian penchant for plagiarism is working overtime, and the new and dynamic Janata thinking on health is a smooth follow-up of an earlier 'populist' government's claim that the social action strategies evolved by China in its road to socialism can be replicated, by implication, without the Chinese kind of revolution and the social philosophy which inspires the Chinese system. While prominent political leaders of the Congress Raj in its most virulently socialistic phase were going around proclaiming the need for "barefoot doctors", a Ministry of Health and Family Planning - instituted Group on Medical Education and Support Manpower in its Report "Health Services and Medical Education : A Programme for Immediate Action" (1975) elaborated on the rationale of rejecting the Western model of health services characterised by huge cost, over-professionalisation and loss of individual autonomy, and of creating an alternative which would emphasise the community's responsibilities in health and involve every individual in fulfilling these responsibilities. It recommended the operationalisation of this alternative model through integration of the professional services with a new cadre of semi-professionals recruited from among the community itself, and reorientation of the health services towards promotion and prevention over cure.

II

The apparent uniqueness of the new rural health scheme lies in its following features:

(i) It is the first attempt to demystify health care technology by emphasising the fact that the elementary understanding of health and medicine is within the grasp of the common man. This is done by extending participation in the health care delivery system to the people themselves, reflected in the institution of the Community Health Worker (CHW) who is chosen from within the village and who in turn educates the public on how best to improve their health environment and prevent disease;

(ii) It is the first attempt to overcome the limitations of health services delivered through government - controlled professional staff alone, in view of the inadequacy, organisational weaknesses and social isolation which characterise these services, and to supplement them with a band of trained, voluntary workers who enjoy rapport with the people at large, are dedicated to community service and are free from petty bureaucratic considerations;

(iii) It is the first time that the allopathic and Indian systems of medicine, i.e. Ayurveda, Unani and Siddha, including Homeopathy, are being combined to provide 'appropriate technologies' of health care which may be both economically feasible and culturally acceptable in the rural areas.

Since October 1977, two batches of Community Health Workers or Jan Swasthya Rakshaks as they are called, have been trained and sent into the field and the third batch has just begun its training. This makes a total of 30,600 CHWs in the field with another 20,000 in making, the numbers having increased considerably with the third batch. The scheme has been introduced on a pilot basis in a total of 777 Primary Health Centres (PHCs) in six States in the country, namely, Andhra Pradesh, Gujarat, Haryana, Punjab, Uttar Pradesh and Maharashtra, and the estimated expenditure on the scheme during the last six months is a little over Rs.4.26 crores.

The idea is to prepare a critical minimum structure for developing a mass-based health services delivery system over the entire length and breadth of the country. The natural starting point for such a scheme would be the areas with relatively better social overheads, and the PHCs which have been selected in the first phase comprise the relatively better-endowed or more favourably located centres. One set comprises all the PHCs of twenty-eight districts where the reorientation of health workers from unipurpose to multi-purpose is complete. The other set consists of one PHC each from the remaining districts of the six states.

The nature of the reorganisation of the health services system from unipurpose to multipurpose in the twenty-eight districts is influenced by the Kartar Singh Committee (1973) recommendations that the health services should be made more accessible to a wider range of the population, and the health workers made more versatile than they have been hitherto, thereby increasing the range and effectiveness of the system. In almost all spheres of social organisation and planning, there has been of late a growing awareness that the main reason behind the failure of social and economic schemes has been the unilateral task-oriented approach ignoring the complex interrelationships which go into any arrangement. It is only by adopting a multi-purpose approach which ensures that all the interrelated socio-economic factors impinging on a particular problem have been taken into account and controlled, that one can be reasonably certain of the chances of success. The logic of this approach is no less relevant to health problems. The multipurpose scheme in the new reorganisation of the health services system seeks to correct the earlier approach to health where a diverse range of workers were commissioned to take care of individual aspects of health such as sanitation, epidemic control, family planning, etc. This fragmented approach (which was largely a result of the fact that the different health programmes functioned independently of each other with little co-ordination between the workers of each programme) is now sought to be replaced by an integrated one whereby the various individual tasks of promotion, prevention and cure are interrelated and the effort is directed towards improving the general environment for health rather than remaining disease-oriented. These interrelated tasks are now sought to be combined in a single multipurpose health worker.

The earlier position was one where under the umbrella of the PHC (there is one PHC per block, for about one lakh population) and its sub-centres (each PHC has eight to ten sub-centres, with one sub-centre responsible for 10,000 population), there were five family planning health assistants, one sanitary inspector, one or two health inspectors, one small-pox supervisor, four basic health workers and four vaccinators who were expected to service the entire block. Besides these, there are the auxiliary nurse midwives (ANMs) who are supposed to look after one sub-centre each but who in practice are often expected to service the impossible number of twenty to thirty thousand. The reorganisation has involved the 'transformation' of these unipurpose workers into multipurpose workers, i.e. they are no longer called sanitary inspectors or vaccinators but, after a brief training, have all been redesignated multipurpose workers, responsible for the multiple health needs of the population, with one male and one female worker allotted to each sector of seven to ten thousand population, supervised by one male supervisor for every three male health workers and one female supervisor for every six female health workers.

In those remaining districts in these States where this shift from unipurpose health care to the multipurpose package has not taken place, the scheme has been launched on a pilot basis by selecting one PHC from every district, the criterion being its proximity to the district headquarters. This is because at the initial stages of experimentation it is necessary that there is a live interaction between the PHC and the district headquarters in terms of communicating the philosophy of the scheme, facilitating the operation mechanism and ensuring a proper feedback.

III

If the Janata Government can take the credit for putting the idea of the barefoot doctor into action, it is also running ahead of itself in wanting to know what the idea feels and looks like. Over March and April, barely six months since the launching of the scheme, evaluation teams commissioned by the government have been attempting to assess the success of the scheme, to culminate in a Report which is probably in Mr. Raj Narain's hands by now. While the periodical evaluation of a programme right from its initial stages is extremely desirable, one wonders how

much of the scheme's objectives could have been achieved within the space of six months to warrant a massive evaluation which must be costing the exchequer almost as much as its meagre annual budget for health (considering the 'prestigious' and elite character of many of the evaluating agencies). While the government-commissioned evaluation is on a large scale and its findings must be eagerly awaited, we would like to report the findings of a modest attempt we made to observe the functioning of the scheme in some parts of Uttar Pradesh. What follows is an account of the teething troubles which have embroiled the scheme in this part of the country.

The operation of the CHW scheme is to be along the following lines. There is to be one CHW per 1000 population which roughly works out to one CHW per village, those villages having significantly smaller populations to be merged with their bigger neighbours. The village is supposed to select one person either man or woman (i) who is a permanent resident of the village and who, in addition to his other work will be able to devote two to three hours a day for community health activities, (ii) who has at least a 6th class education, (iii) who is below 30 years of age, (iv) who would be willing to serve for a minimum period of three years as a CHW, (v) who is acceptable to all sections of the community, and (vi) who does not belong to any "group, faction or political organisation of the village", which may limit his acceptability. Additional qualifications would be (i) if he is a social service minded person and (ii) if he is already a practitioner of traditional medicine.

The most important feature of the selection therefore, according to the government guidelines for the scheme, is that it must be unanimous, and the villages are to be urged to ensure that a single, 'non-controversial' candidate is selected and sent to the PHC headquarters for training. In the rare event of a village not being able to decide on any one name, two or three names may be recommended by the village, the final selection to be made by the medical officers of the PHC in consultation with the Block Development Officer (BDO), Block Pramukh, Village Level Worker (VLW) and other health workers (e.g. Basic Health Worker (BHW), Auxiliary Nurse Midwife (ANM), and Family Planning Health Assistants (FPHA) who would be familiar with the village. The actual selection procedure which will be

followed in these cases is left to the medical officers' decision, but would broadly involve scrutiny of nominations and interviews of candidates. Villages are to be instructed that in the event of any CHW dropping out or violating the three year stipulation, the village if it so desires may send another candidate for training but he would forfeit his stipend. The official control over the CHW is supposed to end here. No disciplinary action can be taken against absenteeism during the training period nor has the health administration any control over the CHW once he has completed his training.

The CHW is expected to fill the most crucial gap that exists in the prevailing health services system, viz. a live contact with the mass of people at the level of the family and household. The training of the CHW consists largely of the elementary and indispensable ingredients of prevention with a limited introduction to a few basic and common drugs. On running through the CHW's Manual the following broad outlines are revealed : an introduction to the most important and common communicable diseases such as small-pox, malaria, filariasis, cholera, jaundice, leprosy, eye infections, polio, etc. : the mode of disease-transmission and factors affecting the spread of the disease in each of these cases, the identification of the disease, preventive measures and presumptive treatment, and special instruction on how to educate the community on these diseases and get their cooperation in implementing preventive measures. The CHW is also taught the rudiments of environmental sanitation, personal hygiene, water supply, home sanitation and food hygiene, control of insects, rodents and stray dogs, maternal and child health care, family planning, immunisation and nutrition. He is taught simple anatomy, first aid and how to dispense and administer drugs for minor ailments. The curriculum includes instruction and practical demonstration on how to make thick and thin blood films to be despatched for laboratory examination in case of malaria, how to keep records of cases treated whether for accidents, minor ailments or for major communicable diseases, records of births and deaths in the village, of chlorinated wells and of drugs dispensed. Finally, the CHW is taught yoga, and the elementary principles of unani, siddha, ayurveda and homeopathy and the treatment available in each of these systems for common ailments.

The curriculum has been designed with a view to equip the CHW in a manner where he can aid the health workers (of the PHC and its sub-centres) in discharging their duties more effectively. This would be mainly through his minute knowledge of the health status of every family in the village, preparation of the ground in the village for immunisation by the health workers, alerting the health workers about the possible breakout of an epidemic, and promptly referring important cases to the PHC doctors.

The course extends over three months for a total of 113 sessions which include lectures and practicals. The training is conducted at the PHC headquarters by all the health workers attached to the PHC under the overall supervision of the Medical Officer In-Charge (MOIC) of the PHC. A new addition to the PHC personnel at the PHC headquarters in those Blocks where the scheme has been launched is a third medical officer who must be qualified in at least one of the Indian systems of medicine (ISM). An important part of his duties consists of active assistance and guidance to the CHWs. He is expected to look after the ISM aspect of their training and to manage the PHC clinic for two days in the week when patients would be treated in accordance with the ISM.

During the training period the trainees are paid a monthly stipend of Rs.200/- and on confirmation they are given a first-aid kit and a set of allopathic, unani, siddha, ayurvedic and homeopathic medicines along with an assurance of a Rs.50/- p.m. honorarium for continuing their health work in the villages. The scheme also includes a provision of a monthly supply of medicines worth Rs.50/- by the government to the CHWs in the field.

IV

Our very first observation was that even by March-April of this year, the scheme had not gone into operation in the real sense of the term. While health officials all the way down from the State level to the PHC level were able and eager to discuss their views on the methods and related problems of selection and recruitment of the CHWs, they had very little to say on how exactly the CHWs were performing their tasks in their respective villages, or on whether the expected enhanced interaction between the PHC personnel and their target population had really occurred

in any significant measure. This is because (i) only two batches had been trained so far and even their scope for effective action had been severely restricted by the inordinate delays in the supply of Manuals and medicines; both the Manuals and the medicines and kits for the first batch had arrived two months after their training and those of the second were still in the offing; (ii) in the absence of any government thinking on how to assess the performance of the CHWs and the progress of the scheme, and the weak communication links that exist within the health administration machinery, there was little that could be definitely said about the most important aspect of the scheme, viz., the impact of the scheme upon the health status of the rural population; and (iii) the considerable government vagueness surrounding certain important aspects of the scheme particularly relating to recruitment, coupled with contradictory instructions issued from time to time, sometimes differently to different PHCs, have resulted in the rather unhappy situation where even those PHCs which felt the need to be innovative in relation to their situation preferred to be cautious instead, while most others took the line of least resistance and admitted to implementing the scheme "as and how possible".

It is only with the passing out of the second batch and the recruitment of the third that the full implications of the scheme have begun to be understood in the villages which are being called upon to select their representatives; and as yet even this understanding is confined to the rich and powerful sections and to those more educated and conscious elements among the relatively underprivileged. This is probably due to the particular nature of the links between daktary and economic and political aspects of the agrarian social structure. The links between the social prestige surrounding the ability to do angrezi daktary in a disease-ridden, highly inegalitarian society along with the possibilities it offers as a lucrative side-profession, and the proclivity of the rural elite to become the standard bearers of every new government scheme, may not be all that tenuous. If the significantly changed situation since March-April is anything to go by, it is only a portent of the further contradictions that are likely to emerge as the scheme gets underway, and it may not be too surprising if the scheme gets so bogged down by the tensions generated around the recruitment of the CHWs that its impact on the health status of the rural population remains negligible.

The most important problems which have begun to plague the CHW scheme centre around two interrelated aspects of selection and recruitment, i.e., the criteria of selection and the procedures of selection. The criterion which has been most violated is that which prescribes that the CHW must be a neutral person and unanimously selected by the village community. It is common knowledge that in many village gram sabhas do not exist, and in many others they do not meet. Our observations universally revealed that the CHWs selected so far largely hail from the richer, more powerful sections of the village, often being Pradhans themselves or relatives of Pradhans. While even in the case of the first batch this was by and large true, we come across some cases of genuine enthusiasm for community health work. This is largely because at that time the scheme was still new. Not much was known about the Rs.200/- p.m. stipend during training and the Rs.50/- p.m. honorarium thereafter. The scheme was perceived more in the nature of a voluntary scheme and mostly those with a natural inclination for this kind of work were selected. Moreover, the enthusiasm for launching the scheme on 2nd October provided very little time for the behind-the-scene manoevres that might have otherwise taken place.

By the time the second batch was being selected, however, word had got around about the pecuniary benefits to be gained by becoming a CHW, and with the recruitment of the third batch the selection of the CHWs has assumed political proportions as well.

Soon after the second batch was recruited and began its training, complaints began pouring into the PHC headquarters challenging the validity of the selections. Petitions claimed that the so-called unanimous selections were a fake, that the Pradhans had not given any chance to others but had sent in their own men, and that they had actively, sometimes even violently discouraged others from submitting their names for the final selection. In some cases the petitioners were Pradhans themselves who had somehow been bypassed, and were now asking that a fresh selection be made in favour of a more qualified person in the village, the person invariably being the Pradhan's own relative !

In December some PHCs received a circular from the State Government to the effect that the selection of the CHW should not be left to the villages; that they should be asked to nominate two or three names to a selection committee consisting of the PHC medical officers, the BDO and the Block Pramukh. However, what has been happening here is that the names still have to come through the village Pradhan who in connivance with the Block Pramukh manages to bring in his own candidate by manipulating the panel of candidatesin a manner which leaves his candidate the obvious choice. In some cases it is the BDOs who take the role of manipulators, and invariably the motive is to make some extra money. The interplay of the various vested interests in the selection process has vitiated the scheme to a great extent and the controversies arising therefrom have been so numerous that in some cases the MOICs upon whom rests the responsibility of launching the scheme have felt compelled to bypass the BDO and do the selection themselves. This is not to suggest that all medical officers have been above the considerations of patronage and spoils. Allegations of corruption and demands that selections be held null and void have even been taken to the courts and in this region there are several cases of CHWs whose selections have been 'stayed'.

At one of the district headquarters we visited, the Chief Medical Officer worked himself up into a rage when he discussed the phenomenon of selection. He claimed that on an average the district headquarters received 25 petitions a day, challenging earlier selections and asking for reselections. When disputes arose and tension started brewing making it difficult for the selected CHW to attend his classes, the medical officers were forced to intervene. Much of their time was taken up in travelling to the concerned villages or enquiring into the matter. All this only adversely affected the working of the health administration, creating considerable confusion within it and overburdening the medical staff.

The ticklish problem of selection has remained an unresolved one. So far the PHC personnel have been satisfied with calling a meeting of all village Pradhans at the PHC headquarters and requesting them to carry the message back to their respective villages. The assumption here is that the Pradhans will conduct the nominations through a meeting of the gram sabha. We have seen the consequences of this approach which places reliance on the rural elite.

As a way out the U.P. Government has decided that the earlier unanimous selection procedure should be universally dropped and that each village should send in three nominations. The medical officers would now be responsible for both the communication of the scheme and the selection of the CHWs. However, there still remain certain methodological snags in this respect. There is some vague talk that the PHC personnel could be asked to go to each village, call a meeting of the entire village and explain the scheme. But logically the responsibility for the scheme cannot end there. The PHC personnel would have to involve themselves at every stage of the selection procedure including that of nominations if they are to ensure that the nominations are done democratically. But this would involve additional work for the medical officers who are already overburdened. Medical officers have complained that they have been given neither extra monetary compensation nor facilities for travel, secretarial assistance, etc., to take care of the considerable expenditure of time and money involved in launching the scheme.

To what extent the desire of the state health administration to ensure through various means the selection of the right kind of CHWs will actually materialise, may prove to be doubtful in the light of the latest developments with the third batch, i.e., the politicalisation of the CHW's selection. In many parts of the state the factional fights at the village level over the CHW selection have been on the basis of political affiliation. In some villages the selection of the CHW has assumed election-like proportions, complete with electioneering and ballot papers printed under different party symbols. MLAs, MPs and Ministers from Lucknow have not been above meddling in these affairs, and political pressures have been brought down on the district health headquarters to fix quotas for each party, something which is not within the jurisdiction of the district medical authorities.

Just one more brief point relating to selection and we would be done with this aspect of our discussion. As regards education, it has been the experience, particularly of the second and third batches that the candidates for CHWs fulfil much more than the minimum 6th standard qualification, some volunteers being even M.Scs and LLBs, thus giving rise to the need for rethinking on this criterion. It is the unanimous opinion of health officials that while the minimum limit should be high school where possible, considering the inadequacy of a 6th class education for grasping the instruction imparted, the maximum should not exceed Intermediate as

graduates and postgraduates volunteer for the scheme only for employment reasons and would abandon their duties for better prospects. By the same token, it is felt, students should be disqualified from selection. The related criterion of age has also required some reformulation, it now being generally agreed by all parties involved in the scheme that the minimum and maximum limits should be 25 and 40 respectively.

One of the important pre-requisites of the new health scheme is that the unipurpose health workers are transformed into multipurpose workers. However it is our experience that this conversion continues to remain only on paper. As one senior health official put it, there are today in this area neither unipurpose nor multipurpose workers. The specialised health workers (such as sanitary inspectors, anti-epidemic officers, etc.) are in a considerable state of disarray due to their dissatisfaction with the multipurpose scheme. Their frustration which has resulted in the scheme being 'stayed' by a High Court order arises from the fact that under the new scheme, although the pay scales have been enhanced for all health workers, that of the family planning health assistants who are only high school graduates has risen so drastically that they are now senior to the specialised health workers who are graduates. Another dissatisfied element who has been consigned to a limbo by the multipurpose scheme is the Block Extension Educator (BEE). Formerly the third senior most in the PHC hierarchy after the MOIC and the 2nd medical officer, with the important responsibility of planning and organising the health education programmes for the entire Block and required to possess the minimum qualification of a master's degree in social science, the BEE has been reduced to the MOIC's private assistant under the multipurpose scheme. His pay scales have undergone only a marginal increase, he has not the slightest idea as to why he has been made a P.A. and there is considerable confusion as what his duties now constitute. The dissaffection which has seized the health workers has come in the way of their commitment to their extra duties arising out of the CHW scheme, as well as their effectiveness in discharging them.

One of the repercussions of this unimaginative reshuffling has been the general indifference on the part of the PHC personnel towards the training programme which is conducted at the PHC headquarters by all the PHC personnel under the overall supervision of the MOIC. On the assumption that the health workers would already be imbued with the philosophy and know-how of the multipurpose approach, the scheme provided for

a bare three days' preparation of the health workers for their new role as trainers. Under the circumstances this has proved inadequate. The kind of orientation which is indispensable for implementing a totally new scheme, and particularly one which involves active teaching of villagers who are total novices to ideas of health, requires considerable preparation of the trainers through workshops, where courses can be planned and teaching methods discussed. The present trainers have detracted much from their own impact by their passive lecture method which is unfamiliar to the villagers, and the negligible use of audio-visual teaching aids. Added to this has been the improper attention to practical training and the failure to unequivocally communicate the importance of preventive over curative measures. These more fundamental inadequacies in the training programme have only been further compounded by physical limitations such as lack of classroom and equipment facilities (lack of space is a problem in many PHCs; classes are perforce held in the open or in verandahs in all weather) and unweildy numbers (while in the first batch a class consisted of 15 persons, the number has now increased to 45). Last but not least is the resentment of the PHC staff for being made to shoulder added responsibilities without any extra remuneration. That there is no control over absenteeism among the trainees is an established fact. What regularity the trainers maintain in taking their classes is an open question.

Another aspect of the training which needs mention pertains to the course curriculum and the related issue of the duration of the training period. The decision to teach five systems of medicine - allopathy, ayurveda, unani, siddha and homeopathy - is highly questionable notwithstanding the appropriate technologies argument. In principle three months is too brief a duration for such involved instruction. More important it is highly doubtful whe-ther a 6th class product, considering the state of our educational system, has the capacity to absorb all the instruction which the Manual contains. Neither has any method been devised to check how much he has understood, this inadequacy only being further bolstered by the indifferent approach to practical training. In practice however, very little of the ISM are actually taught as most often there is nobody to do the teaching. The 3rd medical officer who has been appointed at each PHC in the wake of the scheme is expected to impart the instruction in the ISM. No doubt he is also, as is required, trained in one of the ISM. But actually, the 3rd medical officers are persons who have

left their ISM knowledge and practice far behind when they joined the health services as anti-epidemic officers (AEO) in the days when an ISM was like a bad word. After eighteen or twenty years as AEOs, many 3rd medical officers are today close to retirement. In view of the above, not only is their credibility as ISM experts weak; the decision to appoint them to their new posts without any training or refresher programme is highly reprehensible. In those cases where the 3rd medical officer does teach his particular discipline, the other ISM remain on paper. Hence, in effect, the combination of allopathy and the ISM is not fully operative in most PHCs. One danger which must not be overlooked is that CHWs in their new-found image as daktars have not been averse to prescribing anti-biotics and administering injections - which is not at all part of their training. (At one PHC we were informed of three deaths due to faulty administration of injections). The Manual contains charts of symptoms, diseases, and the appropriate remedies in all the ISM. In the absence of systematic training, there is no gainsaying the possibility of a CHW experimenting with prescriptions in the ISM. Yet another factor which is inhibiting the knitting together of allopathy and ISM through the agency of the CHW scheme is that despite the scheme having been in operation for the last six months, neither the 3rd medical officers (who are supposed to practice their medicine on two days in the week at the PHC headquarters) nor the CHWs have received their supply of ayurvedic, unani, siddha and homeopathic drugs.

There have been inordinate delays in the arrival of even allopathic drugs and kits for the CHWs, as mentioned earlier, despite repeated reminders and prolonged correspondence. As of now the medicines and kits come packed in attractive aluminium trunks all the way from Delhi through the State and district headquarters to the PHCs. An unfortunate consequence of this lengthy and faulty supply line, combined with the failure of the training programme to indoctrinate the CHW in the importance of health education and prevention over cure, has resulted in many CHWs not taking their community health duties seriously and preferring to wait for their supply of drugs before they begin their work. The limited supply of drugs distributed to the CHW and the faith of the village folk in allopathic medicines has led many CHWs to buy their own stocks and then dispense them on payment. The villagers do not find this abnormal as they can rarely get medical attention unless they pay even the PHC doctors and other staff, and the doctors of the State dispensaries. The importance of an assured supply of medicines for

the CHW cannot be exaggerated if the scheme is not to flounder on this count, for in conditions of low doctor-population ratio and high disease-incidence, the CHW's status in the village will largely depend on his favourable comparison with the white-coated doctor.

That India affords the possibility of community endeavours which are both implicitly and explicitly non -political in nature is a myth which was exploded by the experience of the Community Development Programme. Perceptive observers of the Indian scene had even then questioned the borrowed sociological concept of a homogeneous village community governed by the ethos of cooperation, wherein different castes and 'economic groups' had common, non-antagonistic interests. The formulation of the new rural health scheme in terms which once again make the neutral, non-controversial, non-political CHW the basis of the new approach to health reveals that the old lessons remain unlearnt. The new scheme is apparently the most recent of the several progressive measures which have been injected into the rural scene over the last thirty years. But the 'neutral' stipulation is a deliberate attempt, clothed in democratic jargon, to gloss over the naked truth that this is a society where 'politics' is a dominant and obstructive force, where even the most elementary democratic processes have not taken root and where, rather, it is the feudal dynamics of patronage and spoils which operate often in the garb of democratic forms. That the village community is sharply divided into bitterly opposed groups with conflicting interests, is reflected in the impasse in which the scheme finds itself barely six months since it started. It has been difficult to select the CHWs leave alone operate the scheme, and what was conceived as a participative, health-promotive community endeavour is fast becoming a source of conflict generation with the powerful economic and political elements in the village trying to dominate the selection process.

Another basic assumption of the scheme is that it is possible to harmonise two diametrically opposed philosophies and administrative approaches. On the one hand, there is the government health administration with its usual channels of delegation of policy and authority, its principle of control and supervision, and its well-knit structure of salary and promotions reflecting rewards and status. On the other hand is the CHW scheme where autonomy replaces supervision, community service replaces careerism, and community gains take precedence over personal profits. The problems of dovetailing the two systems are numerous.

The directive of the Central Health Ministry that the CHWs are peoples' representatives, autonomous and therefore not to be interfered with has unfortunately resulted in the absence of any thinking so far on how to follow up the training of the CHW, ensure feedback, and assess his performance. In other words, the CHWs are trained and sent into the field and abandoned therewith, the mode of their future interaction with the PHC personnel left undefined. There are no clear plans for theoretical or practical-oriented refresher courses at periodical intervals taking into consideration the CHWs' felt needs. Neither is there any provision for feedback through (i) regular meetings at the sector or sub-centre level between the CHWs and PHC personnel, since staff meetings at the PHC do not include the CHWs, or (ii) encouraging CHWs to keep diaries and hand in regular reports to the PHC. Finally no bench-marks for assessing the CHWs' performance, using, e.g. general health statistics of the village such as mortality, epidemics, etc., have been worked out as yet.

Training the CHWs, maintaining regular contacts with them once they are in the field and helping them to improve their theoretical understanding and practical experience requires far more commitment on the part of the PHC staff than they have hitherto displayed. The general bitterness among the specialised health workers about salary, the hierarchical conditions under which they feel compelled to work, and lack of remuneration for the additional work of training the CHWs, have been the main reasons for this, leaving the indelible impact of the salary and status considerations prevailing in the wider society upon the CHW scheme. Obviously, the scheme could not have remained insulated from the impulses generated by these wider social norms, for the stipend and honorarium which were supposed to aid the CHWs have gradually become the raison d'etre for their entering the scheme. There are sufficient reasons as to why the enterprising and ambitious find the scheme monetarily exciting. It is believed that apart from the Rs.600/- that would accrue to a CHW in the form of the total stipend and the Rs.50/- p.m. honorarium thereafter, he could distribute his monthly stock of medicines worth Rs.50/- for payment, to earn many-fold returns on it. In addition, his newly-acquired credibility as a doctor would bring him further earnings through administering well-known broad-spectrum antibiotics and injections, consultation charges and charges for personally taking a case to the PHC doctor. The social prestige achieved as a Registered Medical Practitioner (RMP) is not to be sneezed at either. Many CHWs have already put up their nameplates proclaiming them to be Dr. so and so, R.M.P. This desire of the CHWs to become RMPs was expressed

when they told us that there were two more obligations the government owed them: one, to confer on them the RMP distinction and the other, to increase their honorarium.

The attempt to reconcile the two conflicting philosophies has also adversely affected the attitudes of the doctors who are required to reorient themselves to the new thinking. The primordial loyalties of persons who have gone through six years of an MBBS course are not easily overcome. The doctors are hesitant in appreciating the CHW scheme. The CHWs in their opinion are mere quacks-in-the-making with a licence to kill, who are in it for the money and enhancement of their "neta" status. More than the CHW it is the 3rd medical officer's presence they bitterly resent : a "mere" unani or ayurved who has now been elevated to a position of equality with an MBBS and draws the same salary. The CHWs on their part are conscious of their intrusion into a carefully stratified system and while they have a feeling of self-confidence and pride in their new role, they are apprehensive about the cooperation they can expect from the doctors.

The problems which hinder the resolution of the two approaches into a concrete and final shape of health practices and philosophies are very much grounded in the historical circumstances which have kept the society disease-ridden on the one hand and perpetuated the elitist character of the allopathic social system on the other. In a society riven by economic inequalities, where the available medical facilities are acutely short of the needs, for any medical practitioner the trade-offs on curative medicine are far greater than recourse to preventive methods. In this also lies the explanation of the resentment of the doctors against the CHWs and the latters' aspirations to acquire the symbols of a doctor. The former's total monopoly over the disease market would now be tampered with, for it is quite possible that the CHWs might start attending more to the curative aspects ignoring their duty towards prevention, because no profits accrue from preventing disease.

If the 'barefoot doctor' scheme which has proved a success in China, has failed to work here in the spirit in which it was conceived, it is because health is a function of the total social structure rather than just one more exotic victim for the latest crash demonstration programme in socialism. As long as the incomes of the poor never rise above starvation level and the trade in human sufferings and disease is a lucrative one, "promotive measures" and "preventive work" will remain so much rhetoric. It is significant that the

Chinese admit that, even after a fundamental restructuring to remove the social and economic inequalities and fifteen years of the operation of the revolutionary rural health services scheme, the struggle to make the scheme more effective on the one hand and to harmonise personal interests with community interests on the other, still continues.

-00o00-

3138